Iowa Department of Human Services

Offer #401-HHS-003: Medical Assistance, Contracts, IowaCare and HIPP

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This offer includes the following appropriations:

Medical Assistance, Medical contracts, IowaCare, HIPP, General Administration, Field Operations

Program Description:

This offer includes the Medicaid program and the administrative costs necessary to administer the program and deliver the health care benefits. Medicaid covers a comprehensive range of health care services for Iowans who meet the program's eligibility criteria. The services are delivered through private hospitals, pharmacies, physicians, nursing facilities, and other health care providers located throughout the state.

The key characteristics of the program are the following:

- Medicaid is a federal program operated by the state. It is an entitlement program under Title XIX of the Social Security Act. That means that the state must cover services to all those found eligible and may not arbitrarily reduce the amount, duration or scope of services.
- The program is financed with state and federal matching funds. Federal funds finance approximately 62% of the Medicaid program in Iowa in typical years. The federal match rate is over 72% at the present time due to the Federal American Recovery and Reinvestment Act (ARRA). However, these additional Federal funds will not be available in SFY 2012.
- Medicaid eligibility is based on a combination of income and other criteria that must be met. Generally, Medicaid covers low income individuals who are aged (over age 65), blind, or disabled, pregnant women, children (under 21 years of age), or members of a family with dependent children.
- Medicaid covers a comprehensive package of acute care services (hospital, pharmacy, physician, etc.) as well as long-term care services (nursing facility, institutional care, and home and community based services) for individuals who are disabled.

All states operate Medicaid programs. While each state's program is different in how expansive their eligibility or service coverage is, or the degree to which they have managed care organizations in their programs, all of the programs are very similar and face similar issues. For example, when the economy worsens, and unemployment increases, more people become eligible for and access the Medicaid program to cover their health needs. This has been true in Iowa, where enrollment increased by 9.4% in FY 2010. In all states, Medicaid programs are a significant part of the health care delivery system. The Iowa Medicaid program is the second largest health care payer in Iowa, following Wellmark. **The program is expected to serve over 656,000 Iowans or 21% of the Iowa population in FY 2012.**

Total Medicaid expenditures (state, county and federal) in FY 2012 will be nearly $4.2 billion. This $4.2 billion will fund payments for medical services to over 38,000 health care providers statewide. Payments are made to physicians, hospitals, labs, pharmacies, home health providers, rural health providers, federally qualified health centers (FQHCs), nursing facilities, chiropractors, physical therapists, home care providers, and many other types of providers. The impact of Medicaid on any individual provider varies by the type of service the provider delivers, and the population they serve. For example, Medicaid makes up between 10-20% of most hospitals' revenues, but is, on average, about 50% of nursing facilities' revenue. In the area of services for the disabled (such as Intermediate Care Facilities for the Mentally Retarded – ICF/MR), Medicaid is often the primary or only revenue source.

The program's match rate brings in nearly $2.4 billion in Federal dollars into the State. In order to draw the Federal funds, the state must fund the required State match. The State matching funds consist of:

- $1,050 million from the State General Fund.
- $107 million from the Health Care Trust Fund (revenue from the tobacco tax).
- $54 million from other funds including the IowaCare Fund, Pharmaceutical Settlement Fund, and the Health Care Transformation Account.
- $46 million from the State Resource Centers.
- $227 million from county/local funds. In Iowa, counties pay for the non-Federal Medicaid match for certain services for adults with chronic mental illness or intellectual disabilities. Other appropriations within the DHS budget are made to the counties that they can use to offset their Medicaid State match costs.
- $214 million from other revenues such as recoveries and drug rebates. Medicaid is an entitlement program, so states primarily control expenditures by either changing the eligibility requirements, the services covered, or the reimbursement rates to providers.
- $6.4 million from the CHIPRA Performance Bonus Payment. The Performance Bonus provides added Federal funding for qualifying States that have increased Medicaid enrollment of children above a baseline level. To qualify during a Federal fiscal year, a State must be implementing during the year at least five of eight program features that simplify the applications and renewal process. The children that count toward the bonus payment are children enrolled in Medicaid who meet eligibility criteria in effect on July 1, 2008. These qualifying children include children enrolled in CHIP-funded Medicaid expansion programs. It is projected that Iowa will qualify for the bonus in SFY 2012.
- **Recently, Iowa enacted two new provider assessment fees.** These fees are charged against providers' total revenues and generate funds that are used to increase Medicaid payment rates to the facilities and also generate a net gain in revenue to the State. These provider assessment fees provide the following in revenue to the Medicaid program:
    - $35.7 million from the Nursing Facility Quality Assurance Trust Fund, implemented April 1, 2010.
    - $39.2 million from the Hospital Health Care Access Trust fund, implemented July 1, 2010.

Medicaid program expenditures grow each year due to enrollment growth and increasing health care costs, just as costs do in the private health care system. Medicaid expenditures grow even more quickly during recessions or economic downturns when more individuals become eligible for and access the program. **The expenditure growth is largely due to growth in enrollment – the average increase in the cost per person has been 0% for the past five years.** Expenditures are also driven

by the cost of long-term care. Nearly half of the Medicaid budget is dedicated to institutional and community based services for elderly and disabled populations who need help with activities of daily living.

Affordable Care Act

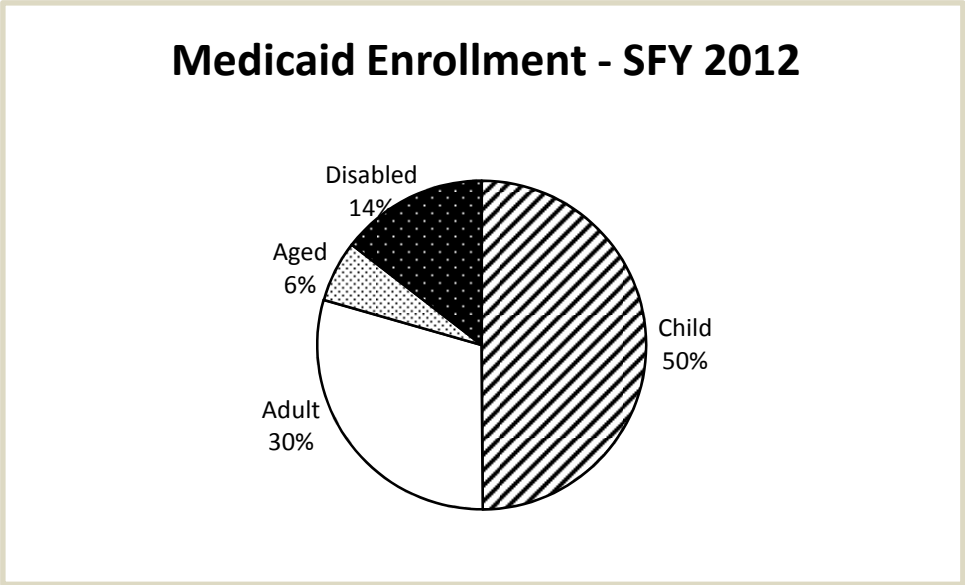
The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 has a number of provisions affecting Medicaid and CHIP. This Federal health care reform legislation is complex. Key changes affecting the state Medicaid programs include:

- Development of 'Exchanges' for individuals to purchase insurance.
- Tax subsidies to assist those between 100% - 400% of the Federal Poverty Level (FPL) to purchase insurance.
- Mandate to expand Medicaid coverage to 133% of the FPL. Eligibility will be based solely on income and no longer limited to those who are aged, blind, disabled, children, pregnant women or members of a family with children.
- New requirements for streamlining Medicaid eligibility procedures.
- Maintenance of effort (MOE) requirement. States are unable to make Medicaid eligibility standards, methodologies or procedures more restrictive until the establishment of the insurance exchanges for adults (effective 1/1/2014) and until 10/1/2019 for children.

The Department recognizes the need to plan and strategize around key components of this Federal legislation, particularly in the area of Medicaid expansion. The expansion will increase Medicaid enrollment in Iowa by approximately 25% (110,000 to 130,000 Iowans) by 2020. This includes the transition of IowaCare enrollees to the full benefit Medicaid plan. This will require the Department to consider options to modify or replace IT systems used for eligibility, enrollment and premium processing to meet the new Federal requirements**.**

Who:

The Department of Human Services estimates that the Medicaid program will have more than 656,000 individual Iowans enrolled over the course of SFY 2012. As noted above, Medicaid will provide health care coverage for over 21% of Iowa's population at some point during a year.



The Medicaid population consists of four general categories and is projected to serve the following in SFY 2012:

- 327,795 children
- 194,019 low-income parents and adults
- 95,466 persons with disabilities
- 39,572 elderly persons

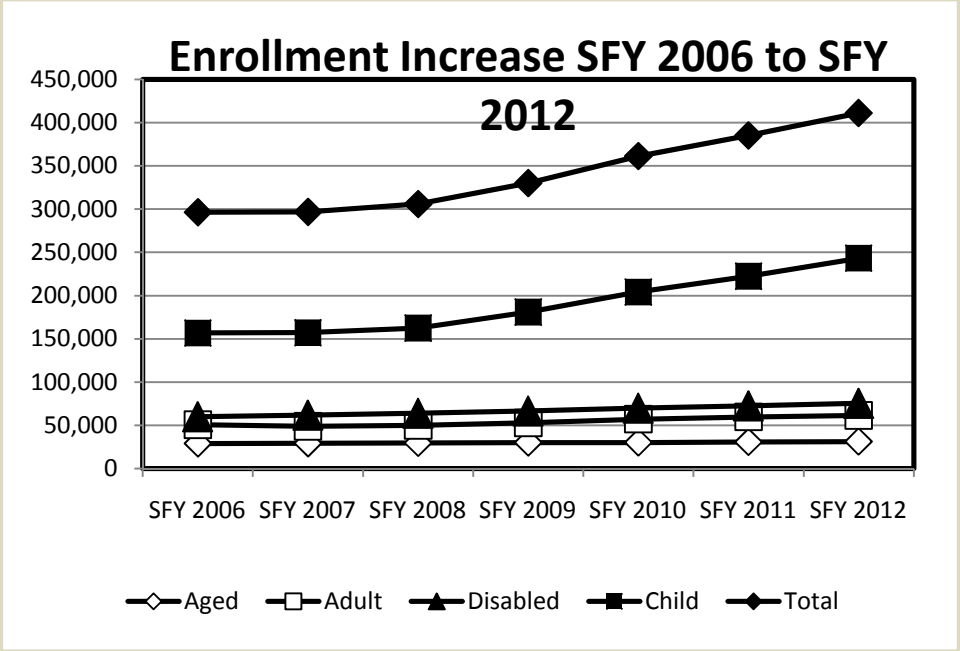
In order to be eligible for Medicaid, individuals must not only be low-income, they must also fall into one of the federally mandated categories: they must be children, frail elderly, disabled persons, pregnant women, or very low-income parents. This leaves many single persons and couples without dependent children ineligible for Medicaid, even if they have no income. Beginning January 1, 2014, under the Affordable Care Act, this will change when Medicaid will cover all Iowans below 133% FPL.

There are several eligibility groups within Medicaid (included in the figures above) that receive a different level of benefits than the 'full-benefit' Medicaid program. These groups typically have higher income and the benefits are targeted to specific populations. These eligibility groups may have premium requirements, more limited benefits, or they may not be entitlements.

- **QMB** - For persons who are Qualified Medicare Beneficiaries (QMB), Medicaid covers only the cost of Medicare premiums, deductibles, and co-payments.
- **IowaCare** – The program is an 1115 demonstration waiver and covers persons (with incomes below 200% of the Federal Poverty Level) who do not fit one of the Medicaid 'categories'. The covered services are limited to inpatient and outpatient hospital services, physician services, and limited dental and transportation services. Members have access to a limited number of providers. Historically, only the University of Iowa Hospitals and Clinics in Iowa City and Broadlawns Hospital in Des Moines were IowaCare providers. Senate File 2356 expanded the provider network to include up to 14 Federally Qualified Health Centers and adopted a medical home model. The FQHC's will be phased in over 2 years, beginning with Siouxland Community Health Center (Sioux City) and Peoples Community Health Clinic (Waterloo) on October 1, 2010. In SFY 2012, the IowaCare program is expected to cover 82,207 adults. (See Appendix for more information about IowaCare).
- **Family Planning Waiver** – The program is also an 1115 waiver and covers women who don't qualify for the regular Medicaid program, up to 200% of the Federal Poverty Level. Women in the Family Planning Waiver receive only family planning services. A projected 34,125 women will receive these services in SFY 2012.

  The 2010 Iowa Acts, HF 2526, Section 11, Subsection 24, requires the department to amend the current medical assistance waiver for the Iowa Family Planning Network (IFPN) effective July 1, 2011, to increase the income limit to 300% of the Federal Poverty Level, to include coverage for women and men up to the age of 55, and to cover women and men whose health insurance does not cover benefits provided under the IFPN. Expansion is dependent on Federal approval and the availability of funding. The Affordable Care Act provides a new option to offer these services through a State Plan amendment, which is less administratively burdensome than an 1115 waiver. DHS intends to convert the waiver to a State Plan Amendment. Funding has not been provided for this expansion in this offer. The department will work with the legislature during the 2011 session to address funding this expansion.

Overall enrollment in Medicaid has been increasing each year since 1996. Enrollment growth increased significantly in SFY 2010. Enrollment increases for children, parents and the disabled were above historical averages, while elderly population growth remained stable. **The largest growth since 1996 is for children. Since the beginning of SFY 2010, Medicaid enrollment increased by 25,456 individuals -- children accounted for 70% of this growth.** The following table shows actual and projected enrollment growth for each category since SFY 2006.



The large growth in children is due both to the economic downturn, where families have lost access to health coverage due to employers dropping health coverage, unaffordable premiums, or losing the job altogether, as well as due to State policy efforts to expand coverage for children**. Iowa policymakers have established a goal of covering all uninsured eligible children. Specifically, the department was to cover more than 25,000 children in three years.** To accomplish this goal, the Iowa General Assembly and the Governor enacted a series of initiatives in 2009 (SF 389) designed to expand coverage and increase enrollment in Medicaid. These include:

- **Expanding eligibility to 300% of the Federal Poverty Level effective July 1, 2009.** Note: in the Medicaid program this only applied to infants less than one year of age; the rest of the expansion occurred in the ***hawk-i*** program (see ***hawk-i*** offer for more detail).
- **Presumptive Eligibility** – This change will allow children to receive services during the time their formal application is being processed. It will also allow families to initiate enrollment through qualified entities which include medical providers and other community organizations, rather than only through the local DHS office. This change began in March, 2010.
- **Express Lane Eligibility –** This change will streamline eligibility for children whose families are already enrolled in food assistance, but are not enrolled in Medicaid. It will begin in September 2010.
- **Increased public awareness campaigns** about Medicaid to encourage families to apply.
- SF 389 also directs the department to implement other policies to streamline application and enrollment processes.

In 2010, 28,529 children were enrolled in either Medicaid or CHIP. This exceeds the original goal of covering 25,000 in three years.

What:

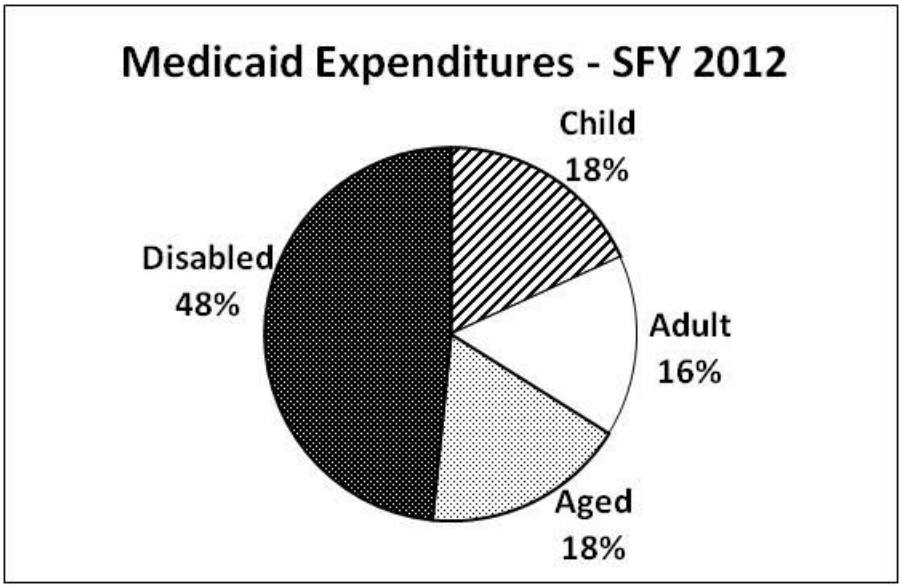
Iowa Medicaid pays for medically necessary health care services, including acute care services typically covered in any health insurance program. These include hospitalization, physician and advanced registered nurse practitioner (ARNP) services, dental care, emergency transportation by

ambulance, laboratory, x-ray, and other services. Coverage also includes comprehensive mental health services delivered through a contracted managed care entity (known as the Iowa Plan), and includes rehabilitative mental health services (known as remedial services). Iowa revised the Remedial Services program in 2006 to allow all children in Medicaid to access the service. Previously, services could only be accessed by children being served in the Child Welfare system. This program will transition to the Iowa Plan in SFY 2012.

The Medicaid program has a panel of more than 38,000 dedicated providers including hospitals, physicians, dentists, pharmacies, medical equipment providers, and many other health care providers of all types.

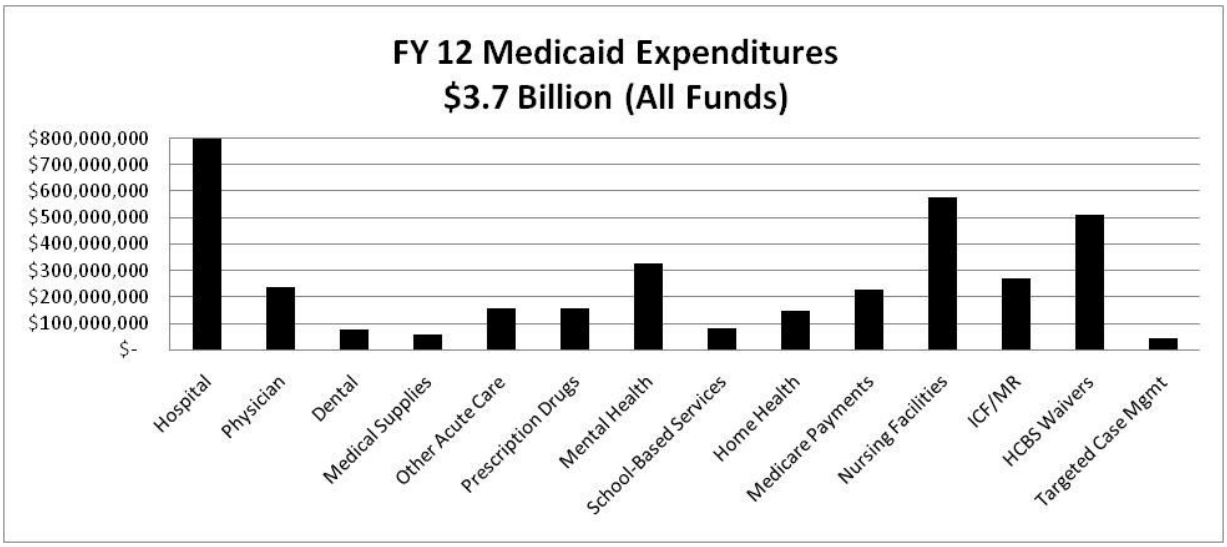
In addition to traditional acute care services, Medicaid provides coverage for long-term care services, such as nursing home care, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and home and community based care that allows individuals to stay in their own homes or other small congregate settings. Long-term care services provided at home, such as home health, assistance with personal care, homemaking, and respite care allow individuals to avoid or delay institutional care.

Home and community based care is delivered through seven 1915(c) waivers that are targeted to specific populations including: Elderly, persons with Intellectual Disabilities, persons with Physical Disabilities, Children with Serious Emotional Disturbance, HIV/AIDS, Ill and Handicapped and persons with Brain Injury. The waiver programs are typically less expensive than institutional care and have a great deal of demand – all waivers, except the Elderly waiver, have waiting lists for new enrollees. Some waiting lists are over a year long to access the programs. This speaks to the desire of members to live in their own homes and communities as much as possible. In Iowa, and nationally, Medicaid programs finance the majority of services in the disability system, and for approximately half of nursing facility care. Counties pay the non-federal share for services to adults with intellectual disabilities and for certain services for adults with mental illness.



The cost of medical care for different Medicaid populations varies significantly. **The average cost for each child in Medicaid is much lower than the average cost for each disabled or elderly person, since elderly and disabled individuals utilize more long-term care services. As shown in the**

charts above, although children make up 50% of the Medicaid population, they account for only 18% of total expenditures. This difference is true nationally as well. As noted above, there are a number of smaller programs within Medicaid that cover only a subset of the full-benefit package.



The table above reflects Medicaid provider payments across major service categories. In addition, this offer includes other transfers and administrative costs that total $4.2 billion dollars. **Acute care expenditures account for approximately $2.3 billion in expenditures, while long term care (the last 4 categories on the right side) account for $1.4 billion.**

How:

Medicaid pays for Medicaid covered services that are provided to eligible members, by enrolled Medicaid providers. The reimbursement methods vary across provider types. Medicaid is the 'payor of last resort', and as such has reimbursement rates that are often lower than private insurance or Medicare. For providers that serve almost exclusively Medicaid members (i.e. long term care providers), the rates are based on the cost of service.

Medicaid, as a payor of health care services, has all of the same responsibilities as any third party payor. The administration for the program is known as the Iowa Medicaid Enterprise (IME). The core business functions of operating the program include the following:

- Processing and paying claims submitted by providers for services they delivered to members. Medicaid pays nearly 23 million claims per year. **The average time from receipt of the claim to payment is less than seven days.**
- Medical management functions are performed by medical professionals and include prior authorization of certain services to ensure the service is medically necessary, ensuring members meet the 'level of care' requirements to receive long term care services, disease management programs, quality assurance, review of utilization to ensure the program is cost effective in the services provided.
- Provider network management, including contracting with providers, provider services call center and training, and reimbursement analysis and rate setting.
- Member services call center.

- Cost avoidance and recovery when other insurance is present, from estates, insurance settlements and drug rebates (Medicaid collects over $179 million in revenue to offset state and Federal costs).
- Pharmacy management and claims payment. IME operates a Preferred Drug List that saves the state over $30 million annually.

Iowa has undertaken innovative approaches to managing these programs and improving the quality of services. Iowa seeks to not simply be a payor of health services, but to manage high quality and cost-effective health care. The Iowa Medicaid Enterprise operates the Medicaid and IowaCare programs by integrating "best in breed" private contractors to efficiently process medical claims, work with providers and members, and aggressively pursue cost recovery. Provider surveys show satisfaction has increased since implementation of the IME. Average wait time for a provider to talk to a call center representative is less than 20 seconds.

Medicaid will also pay the premiums for private insurance if cost effective (called the Health Insurance Premium Payment Program (HIPP). **The HIPP program provides a net savings to the Medical program of over $2.3 million.** Historically, the administrative costs for the HIPP program have been in a separate appropriation. The department recommends consolidating the HIPP program within the Medical Assistance appropriation in the SFY 2012 budget.

Other strategies include disease management programs, smoking cessation coverage, an electronic health record, preventive medical exams, Medicaid Value Management (MVM) which allows us to identify areas we need to target management strategies, multi-state drug purchasing pool, Preferred Drug List, and premiums. **In the past year, Medicaid has significantly expanded program integrity efforts to pursue overpayments, identify coding errors and identify fraud and abuse. These increased efforts are projected to result in savings and cost avoidance to the Medicaid program of $20 million (State and Federal)**

The Medicaid program also has responsibility for contracting with other agencies, such as the Department of Public Health for various health education and care coordination programs for children.

Service Delivery
Iowans access the program by submitting an application through the local DHS field offices. Local field staff determine eligibility for the program. This offer includes funding for 451.30 FTEs located in the local county offices who determine eligibility for the program, and manage the on-going cancellations and redeterminations that are required at least annually for the over 500,000 members on the program. Note that funding for eligibility workers has not kept pace with growing enrollment, so each year workers are managing more and more cases. This increased workload impacts the performance of the staff and increases the risk of higher error rates, meaning individuals are either made eligible or ineligible in error. Error rates are audited regularly by the Federal government.

As part of the SFY 2011 Field reorganization, a centralized unit for facility medical will process all Medicaid applications and ongoing actions associated with residents in Medical Institutions, specifically, ICF, ICF-MR, ICF-MI, PMI, hospital only, and Medical Rehabilitation Centers. This unit will (a) determine SSI-related and/or FMAP related eligibility of residents residing in these institutions, as needed and (b) process other Medicaid coverage groups of residents of Medical Institutions, as appropriate. Staffing for the new central unit is 20 income maintenance staff with a caseload of 698.

Once eligible, the covered health services are available through any of the 38,000 enrolled Medicaid providers. Medicaid pays providers for the services delivered.

Service Support
The Medicaid program is administered by the Iowa Medicaid Enterprise (IME). The IME is made up of 25 State FTEs (excluding CHIP staff) managing nine performance based contracts with private vendors. The state FTEs perform the policy function and management of the vendors. The vendors carry out the majority of the business functions of operating the program. State and contract staff are co-located in a single facility to ensure integration of the vendor operations with the program management. The funding for the state staff is included in the "General Administration" appropriation, and all Medicaid contracts are funded from the "Medical Contracts" appropriation.

General Administration budget for Medicaid includes 25 State FTEs with direct Medicaid administration responsibilities, as well 77.42 FTEs for all other administrative functions such as budget and accounting, Information Technology, Personnel, etc. The General Administration budget includes State staff who are directly responsible for providing program oversight and support, performing the following functions:

- Overall Departmental oversight
- Program Support – policy development, administrative rules, provider and employee manual, Medicaid State Plan, Iowa Code
- Member and Provider Relations – appeals, exceptions to policy
- Communication – State/Federal relations, legislative requests
- Legal Support via the Iowa Attorney General's Office
- Information Technology – maintenance of existing systems and development of new and/or enhanced systems to improve efficiencies and customer service
- Financial Accountability – budget, accounting, federal/state reporting, cost allocation, audit coordination and resolution
- Contract Management/Purchase of Services
- Postage – distribution of provider payments
- Responsible for compliance and administration of the Medicaid program

In addition to the Field and General Administration FTEs, this offer includes 11 FTEs to administer the Health Insurance Premium Payment program.

Following is a summary of expenditures included within this offer broken down by:

- Program Costs -- $4,011,285,653
- Service Delivery Costs (field or facility staff; contractors who provide services) -- $36,673,162
- Service Support Costs (administrative contracts; general administration) -- $122,461,501

American Recovery and Reinvestment Act of 2009 (ARRA): Increased Federal Match Rate

ARRA authorized an estimated $87 billion in additional federal funding for states, in the form of a temporary increase in the funds that the Federal government contributes toward Medicaid and Title IV-E programs. The increased match rate was originally scheduled to be available for 27 months between October 1, 2008 and December 31, 2010. An extension through June 30, 2011 was recently enacted by Congress, although at a reduced rate from what was expected. An increase in the Federal Medical Assistance Percentage (FMAP) formula offsets State dollars needed to fund the Medicaid program.

These dollars have helped to avoid major reductions in Medicaid and other DHS programs during the recession period.

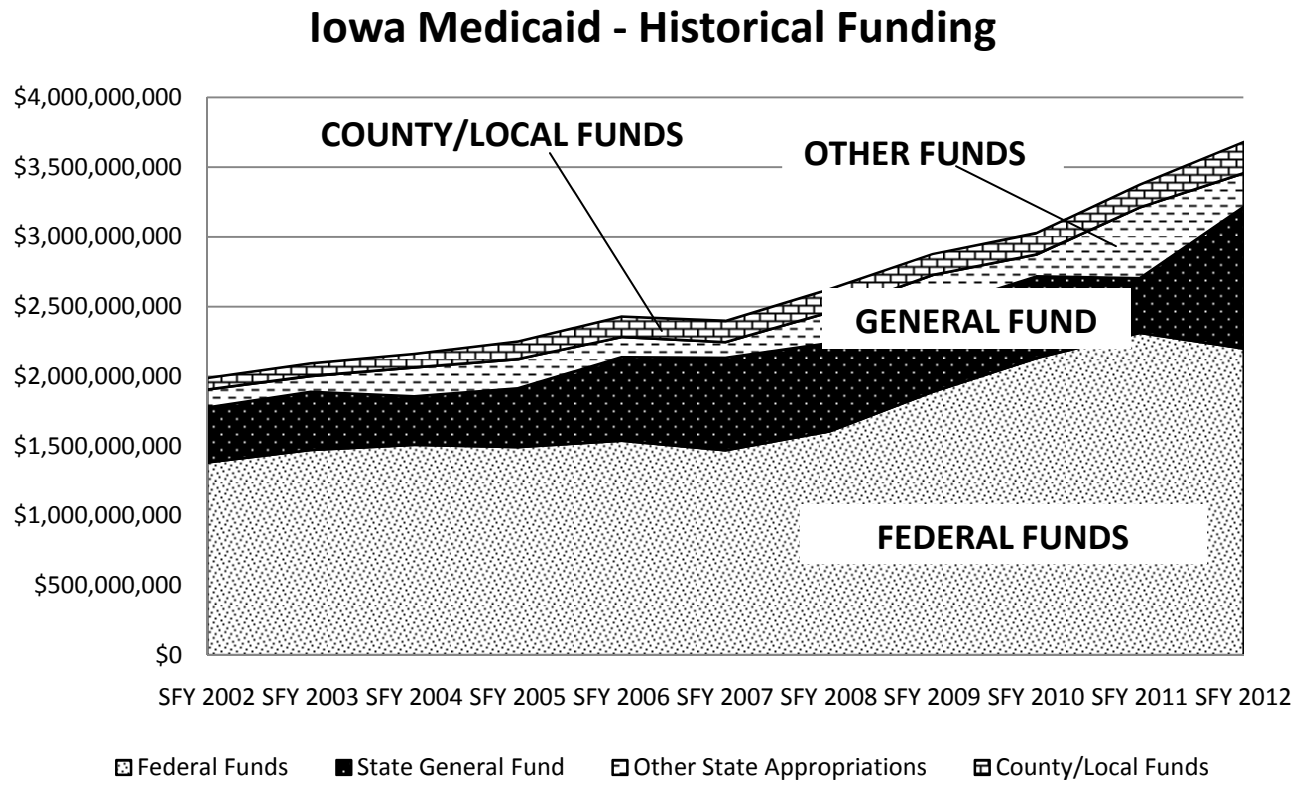
As a result of ARRA, Iowa's SFY 2011 FMAP rate is expected to be 70.64%. Without the ARRA legislation, the FMAP rate would have been 62.85%. This higher FMAP rate is expected to increase Federal participation by $196 million in SFY 2011. Put differently, this results in State spending being $196 million less than it otherwise would have been had ARRA not been passed.

The increased ARRA FMAP will no longer be available in SFY 2012. As a result, the State Medicaid appropriation will need to replace the entire $196 million in Federal ARRA dollars that were available in the prior fiscal year.

Impact of Proposed Budget on Results:

Sustaining service delivery assumes the level of funding requested in the offer as well as full funding of salary adjustment. If funding is insufficient in either area, results to be achieved will be modified to reflect the impact. To sustain existing services and growth in programs this offer assumes that status quo as well as all one-time funding such as the cash reserve fund, underground storage tank fund and government stabilization and stimulus dollars are fully replaced. In Medicaid, one-time funds finance a significant amount of the Medicaid budget in SFY 2011. If these dollars are not available in SFY 2012, there will be significant program reductions and negative impacts such as elimination of services.

- NOTE: Federal Maintenance of Effort in Medicaid prohibits the state from reducing Medicaid eligibility or implementing new waiting lists through SFY 2014.



The preceding chart shows the financing for Medicaid over the past 10 years. In SFY 2011, federal funds increased due to ARRA. Also, the "other funds" were increased and General Funds decreased. These other funds were primarily one-time and are not available in SFY 2012. **Therefore the General Fund share increases in SFY 2012 to offset the loss of one-time state and federal ARRA funds.**

Current Results:

The offer maintains the current eligibility levels and covered services for recipients of Medicaid and IowaCare. The offer addresses projected growth in enrollment in the program due to economic conditions, as well as changes in utilization patterns and costs.

In total, this offer results in an increase in General Fund support from the adjusted status quo level (excluding the ARRA federal dollar replacement amounts) of $167,407,341 for SFY 2012. The offer assumes that the 5% and 2.5% across the board provider rate reductions implemented 12/1/09 and continued in SFY 2011, are also continued in SFY 2012. The detail for the increase is as follows:

- $163,946,404 for increases in the Medical Assistance program. Further detail behind this increase is provided below:
    - $53,463,995 to replace carry-forward dollars that were available in SFY 2011, but will not be available in SFY 2012.
    - $26,188,189 to replace other revenues that will not be available in SFY 2012. This includes an assumed loss of $33.7 million Federal dollars due to a decline in Iowa's regular FMAP rate. This is partially offset by smaller revenue increases including hospital and nursing facility assessment fee revenue and CHIPRA performance bonus payment revenue.
    - $25,760,955 for increases in fee-for-services (such as hospital, physician, laboratory, etc) due to enrollment growth of 6.77% over SFY 2011.
    - $19,735,650 for growth in the utilization of fee-for-service and inflation in cost-based reimbursement.
    - $14,149,973 for increases in Medicare-related payments. This includes growth in the payment of Medicare Part A and Part B premiums and the Medicare Part D clawback payment. The increase is primarily due to an assumed Medicare Part B premium increase of 31% in calendar year 2011.
    - $13,723,553 for nursing facilities; primarily to fund the scheduled nursing facility rate rebasing.
    - $6,129,462 for the home and community-based waivers, due to recipient growth resulting from the annualization of the waiting list buy-down that occurred in SFY 2011; enrollment increases in the Elderly Waiver and utilization/inflation increases in all of the waivers.
    - $4,636,801 for growth in mental health-related services which includes the Iowa Plan, Remedial, Habilitation, PMIC and Psychiatric services. The increase is primarily due to an expected increase in the number of recipients receiving these services. This increase was also partially offset by an assumed transfer of the Remedial Services program to the Iowa Plan.
    - $1,174,730 for managed care increases. This is primarily due to the expansion of Iowa's Program of All-Inclusive Care for the Elderly (PACE). A new provider will be joining the PACE program in SFY 2012, and this is expected to increase recipient counts by nearly 50%.

- $712,915 for targeted case management. A 3.76% increase in recipients and 3% increase in costs are assumed.
- ($1,729,819) for increases and decreases in all other Medical Assistance programs/payments. This includes items such as medical transportation, health insurance premium payments, administrative payments, recoveries, and transfers to other appropriations.

- In addition, this offer includes a decrease of $75,841 for Medical Contracts. The reduction is primarily due to lower IME contract transition costs, although this is partially offset by inflationary increases required per the contract agreements.

- $3,409,566 for Field Operations to maintain the current level of services for new cases. In order to timely and accurately determine eligibility for the Medical offer with the same caseload as SFY 2011, Field Operations needs 65.16 FTEs in SFY 2012.

- $127,212 for General Administration inflationary costs to sustain operations and service delivery including workers compensation fees, postage, mainframe computer usage changes, and IT support.

Improved Results:

The Medical Services offer will improve the following results:

- Ensure Federal compliance by adopting a new Medicaid Management Information System (MMIS), allowing the state to improve Medicaid claims processing.
- Establish an effective program to meet Federal regulations to identify and address the needs of individuals with mental retardation or mental illness who my need nursing facility placement.

Medicaid Management Information System (MMIS) Replacement - $3,000,000

The Iowa Medicaid Enterprise operates on a 1970s-era mainframe system to support the Medicaid program. The system, known as the Medicaid Management Information System (MMIS), processes over 23 million medical claims on behalf of 656,000 Iowans and makes payments to over 38,000 private health care providers (physicians, hospitals, pharmacies, labs, etc.). The system supports claims processing, provider network management, managed care operations, and many other functions to operate the $4 billion Medicaid program.

The MMIS has been very stable and served the program well for over 3 decades. However, the system is very rigid, difficult to change, and requires programmers to do time consuming programming for even the most routine changes. This means that policy changes, such as provider rate change, or new services take many hours of programming to implement, and often cannot be implemented in a way that precisely meets what it is supposed to do or causes claims processing errors for providers that require them to resubmit claims multiple times in order to get paid. The system cannot meet the needs of Iowa's Medicaid program, members, and providers any longer. After careful consideration, the Department has determined that we must upgrade to a new system on a modern technology platform.

There are many reasons why this would enhance Medicaid oversight, quality, and cost effectiveness, as well as the level of services we are able to provide providers and members. However, there are several key issues that make this change necessary at this point in time:

- **ICD-10 compliance** – The "International Classification of Disease" (ICD) is the code set used by the entire health care system for diagnosis and disease classification. This code set is used not only in the US, but by the World Health Organization and virtually every nation's health care system. The set currently used in the United States is "ICD-9". ICD-9 is being replaced by a much larger, more complex set of codes – ICD-10. Federal law mandates that all providers and payors (including Medicaid) convert to ICD-10 by October 1, 2013. The code changes needed are so comprehensive that 'upgrading' the current MMIS is impractical. Also, ICD-10 will provide a wealth of increased data that can be used by the Medicaid program to better manage cost and quality. This project is necessary to meet compliance with 45 CFR Part 162. The project also includes required changes to the electronic data transactions between providers and payers, such as NCPDP D.0 that will need to be completed in SFY 2012.
- **Management and Compliance –** The Iowa Medicaid program is now the second largest health care plan in Iowa (after Wellmark) covering 21% of Iowans. Effectively managing a health care program this size has grown increasingly complex. The current MMIS system can no longer provide the granularity and accurate reflection of Medicaid payment and coverage policies necessary to manage the Medicaid program appropriately. The system needs to support the state and Federal requirements for the program, in a constantly changing environment and to be able to support providers effectively. Medicaid is the second largest payor, but we generally pay the lowest reimbursement rates. As such, we need to provide effective administration to allow claims to pay quickly and on-time, e.g. reduce the 'hassle-factor' to retain providers and be responsive and nimble in the face of change. We have reached a point, where our mainframe system is no longer able to support the State's goals and federal requirements.
- **Health Care Reform activities** – Implementation of the Medicaid expansion under the Affordable Care Act (which occurs 3 months after the ICD-10 deadline) will increase the size of the Medicaid program by 25% and require design and payment of a new benefit structure. The state seeks also to implement strategies such as Health Information Technology/Health Information Exchange, Medical Home, Accountable Care Organizations, payment reform, health quality and transparency data reporting. IME fully supports these efforts to transform health care delivery and that the Iowa Medicaid program can play a valuable role in testing, and implementing strategies that policy makers set for the state. However, the current MMIS system holds us back from being able to implement in a reasonable, cost effective way, many of these strategies.
- **Cost of Operation** – Mainframe systems require teams of programmers to make even the smallest changes. Operations and data storage costs are very expensive. Moving to a more modern, service oriented architecture platform will be much less expensive to operate and more flexible to respond to needed changes.
- **Benefits of a new system** – A modern IT platform and software will provide the following benefits to policymakers, Medicaid management staff, providers, and members, including:
    - Benefits to Medicaid Providers:
        - Real time claim adjudication for providers to get immediate feedback on coverage.
        - Auditable claims processing decisions so every rule applied to the claim can be identified.
        - Connection to the Health Information Exchange for medical reviews.
        - Expanded functionality of the provider website portal to reduce paperwork and improve communication.

- Benefits to Medicaid members:
    - Access to explanation of benefits for each claim.
    - Wellness information.
    - Personalized alerts and reminders for healthier outcomes.
    - Management of patient centered care management and medical home assignments.
- Benefits to policymakers and the State:
    - A business rules engine to allow for rapid implementation of new programs, edits, and policy decisions.
    - Increased granularity for pricing decisions.
    - Compliance with MITA (Medicaid Information Technology Architecture) and alignment with current business processes (Federal compliance).
    - Improved security model to meet HIPAA regulations.
    - Improved data capture for management of population health, quality outcomes, predictive modeling, and program integrity.

The Department intends to release a Request for Proposals by January 1, 2011 for a new MMIS system. The goal is to have the system in place by the ICD-10 deadline. This is a very aggressive timeline. Any major system replacement is an expensive, high-risk undertaking. We estimate that the HIPAA 5010 compliance and all work to bring in a new system may total over $76 million over a four-year time horizon. However, we believe we have to move to a new system to meet the program needs and requirements. **The Centers for Medicare and Medicaid Services (CMS) provides 90% Federal match for all MMIS enhancements, and 75% Federal funds for commercial off-the-shelf software.** We anticipate that we will have a combination of 90% and 75% match rates on the total project. The actual cost will not be known until bids are received in the spring of 2011. The preliminary estimate for FY 2012 is $3.0 million in state funds.

NOTE: The new MMIS replacement project does not contemplate the eligibility changes that will be needed for implementation of the Affordable Care Act. At this time, we are not able to estimate the cost impact of that significant system change. An estimate will be developed over the fall 2010.

Preadmission Screening and Resident Review (PASRR) for Nursing Facilities - $190,650
The Department is currently actively engaged in reviewing Iowa's compliance with the federal Preadmission Screening and Resident Review (PASRR) program requirements at 42 CFR 483, Subpart C (483.100-483.138). CMS has issued guidance to states, emphasizing the role and responsibilities of the State Medicaid agency in operating a PASRR program that achieves the purpose of protecting vulnerable individuals diagnosed with mental illness or mental retardation, who may need nursing facility placement. CMS has also issued a series of letters to State Medicaid Directors to identify the expectations of the State Medicaid Agency in demonstrating compliance with the U.S. Supreme Court's *Olmstead* decision, which includes compliant PASRR programs.

Recently, CMS has instructed that Iowa must have a plan submitted to CMS by 9/15/10 to demonstrate Iowa's plan for compliance with the Federal PASRR regulations. The Department plans for IME, in partnership with the Division of Mental Health and Disability Services (MHDS), to establish an effective, statewide program that includes a process to ensure that individuals with mental retardation or mental illness are appropriately screened, thoroughly evaluated, and placed in nursing facilities only when a determination has been made that it is an appropriate placement, and that the resident is receiving all necessary services to meet their needs.

The State is able to secure 75% FFP for the administration of PASRR. This offer includes funding for:

- A position in MHDS to manage and monitor the new process
- A contract for an entity to conduct the Level II evaluations and ensue a provider network,
- The development of a monitoring system and other systems programming necessary to implement.

Legal Requirements:

Title XIX of the Social Security Act authorizes and stipulates the requirements for the Medicaid program. These requirements are further detailed in the Code of Federal Regulations beginning at 42 CFR 440. The Federal regulations require any state that operates a Medicaid program to include, at a minimum, specific services for individuals who fit into defined categories. Federal regulations at 42 CFR 440.210 and 42 CFR 440.220 require that inpatient and outpatient hospital, physician, lab and x-ray, nursing facility, physician services, nurse midwife and nurse practitioner services must be provided. In addition, this requirement indicates attention to care for pregnant women. Further, the Iowa Code also defines the services and eligibility categories the Iowa Medicaid Program is required to cover. This offer maintains our statutorily required services and populations.

Results Achieved:

Result:	SFY10 Actual Level	SFY11 Projected Level	SFY12 Offer Level
Percentage of State long-term care resources devoted to home and community based care. Medicaid strives to assure that members are receiving services in their communities whenever possible. The funds spent for all long-term care is compared to those spent for community services.	25.85%	27.67%	25.61% including the Nursing Facility QA Assessment Fee 28.27% without NF QA Assessment Fee
Proportion of 15-month-old children with 6 well-child visits.	32% *	40%	42%
Proportion of children with an annual dental visit.	54% *	55%	56%
Proportion of persons with asthma where appropriate medications are used.	81%	85%	85%
Proportion of women receiving prenatal care from the first trimester.	68% *	70%	72%

State savings from pharmacy cost saving strategies, including PDL.	$30.4 M (SMAC) Final rebate data not yet available to provide final PDL savings	$36.2 M (SMAC) $31 M (PDL) Note: Do not yet have complete rebate impact due to Health Care Reform	$36.2M (SMAC) $32.9 M (PDL) Note: Do not yet have complete rebate impact due to Health Care Reform
Savings from utilization and care management strategies. The Medical Services Unit reviews requests for prior authorization to determine medical necessity and recommend alternatives. Data on utilization are used to develop a savings over what would have been spent without such oversight.	$21,500,000	$10,000,000 **	$10,700,000
Savings from Surveillance and Utilization Review compared to contract cost. This dedicated unit used nationally accepted standards to search the claims database and find instances where payments may have been made incorrectly. The amount of overpayment recoveries is set by the contract with the entity performing this function.	400%	$20,000,000 ***	$22,500,000
Increase over the prior year in revenue collections from third parties. The collections (including cost avoidance measures) for SFY 2008 were 39.33% higher than the goal. Overall, the enhancement of the goal from year to year as specified in this contract would appear sound. The contracted performance measure is 15%.	-3%	15%	15%

% increase in member satisfaction with administration of Medicaid program over prior year, based on survey results A 2006 survey set the baseline measure. Over the life of the Member Services contract the IME expects the positive rate to increase by 2% each year.	2%	2%	2%
% of members aware of Member Services A survey is performed annually by the Public Policy Center at the U of Iowa. The 2007 study indicated that 43% were aware of the helpline. A more recent survey (2010) is in process and results are not yet available. The increase is an optimistic but achievable demonstration of the effort to make members aware of this helpline.	43%	48%	50%
% increase in provider satisfaction with the Provider Services Unit over prior year, based on survey results The overall performance score for provider satisfaction in 2008 was 3.76. The improvement for 2009 was a 5.01% increase. The goal of 5% per year in incremental improvement is appropriate.	5% (Current Survey Results due to the IME on 9/30/10)	3.85 on 5.0 Scale	3.93 (2% increase over SFY 11)
% of receipt days where clean claims are accurately paid or denied on time as per federal regulations.	100%	100%	100%

The Federal requirement is for 90% of clean claims to be paid in 30 days and 99% in 90 days. The IME currently shows that the average payment delay for a clean claim is less than 10 days.			

* Healthcare Effectiveness Data and Information Set (HEDIS) measures are used to describe these results and are gathered by the University of Iowa Public Policy Center (PPC) annually. These are compared with national standards and benchmarks. HEDIS data reports are currently only available for SFY 2009 (in DRAFT form only at the time of this writing). Actual HEDIS data cannot be utilized until claims data has been finalized and that is generally determined by the PPC at 24 months following the fiscal year. The SFY 2012 and subsequent year goals are taken from the PPC report and recommendations for future year goals.

Table shows projected amount for SFY 2010.

** Beginning in SFY 2011, new performance measures will be implemented based on new contract and scope of work for IME Medical Services.

*** Beginning in SFY 2011, savings is to be determined in $ rather than in %